2. Simultaneous appearance with secondary lesions.
3. Influenced by specific treatment.
4. May vary in degree as the secondary eruption varies in intensity during the course of the disease, and, like the eruptions, may recur.
5. Rapid appearance without digestive disturbances.

Even the grave cases if properly treated are rarely fatal. Treatment consists in ordinary treatment for syphilis in this stage.

LITERATURE.

Total literature is too voluminous to republish in toto. See the following articles, where may be found the majority of citations:

Goujon. Sur l'Ictere de la periode secondaire de la syphilis acquise, Paris Thèse, 1896.

Laubry. L'Ictere syphilitique secondaire, La tribune médicale, 1901, vol. xxxiii. p. 1027.

Werner. Beiträge zur Pathologie des Ikterus syphiliticus, Münch. med. Wochensch., 1897 Bd. xliv. p. 736.

Index Catalogue of the Library of the Surgeon-General's Office.

BRIEF REPORT OF A CASE OF SPRING CONJUNCTIVITIS RESEMBLING MALIGNANT GROWTH OF THE CORNEAL LIMBUS.[1]

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EARLY in October, 1902, H. H., a male, aged twenty-four years, native of Virginia, was brought to me by one of my clinic assistants for the purpose of having a growth removed from the corneal limbus of the right eye. This growth had been observed first about two years before as a small elevation 2 mm. to the temporal side of the limbus in the centre of a small, circumscribed patch of conjunctival injection, and had increased in size until at the time of my examination it was 5 mm. by 7 mm. in breadth and encroaching upon the cornea. It presented an angry, bluish-red appearance, and, though apparently situated in the conjunctiva, was firmly adherent to the underlying episcleral tissue. The patient complained of the disfiguring appearance, sensation of a foreign body, slight burning, and some conjunctival discharge. Further examination of the eyes and lids revealed nothing abnormal, excepting a moderate refractive error, and the patient was confident that the condition had been uninfluenced by the seasons and that the growth had been gradually increasing in size for two years. No family history of tumors of any kind could be obtained.

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[1] Read before the Section on Ophthalmology of the College of Physicians of Philadelphia, March 15, 1904.

The growth was excised under cocaine anæsthesia, the site thoroughly curetted, and healing was prompt, with amelioration of all the symptoms.

The specimen was hardened in a 5 per cent. solution of formalin and sections prepared for microscopic study by Dr. E. A. Shumway. Considering the clinical history just referred to, the condition at the time of examination, and the fact that in the tumor were found small, round mononuclear cells, some pigment, and an alveolar arrangement, together with a tendency of the thickened surface epithelium to proliferate inward, it was thought that we were probably dealing with an alveolar sarcoma, which had developed from a pigmented nævus of the conjunctiva.

In May, 1903, nearly eight months after the operation had been performed, the patient was again seen, and examination showed a marked recurrence on the former site, which, according to the patient's statement, had first been observed two months before, or nearly six months after removal. The appearance of the recurrent growth was not red and angry-looking, as was the original, but of a much paler hue—in fact, markedly resembling a lump of paraffin covered by the delicately tinted conjunctiva.

Expectant treatment was employed, and a few weeks later somewhat similar but smaller patches appeared at the nasal and temporal margins of the left eye, together with three isolated enlarged papillæ of the conjunctiva of the upper lid, the latter now presenting a bluish-white appearance, as if covered by a thin layer of well-diluted milk.

Further study of the microscopic specimens of the original growth at this time, considering the clinical history in its later aspects, proved, beyond doubt, that the condition was spring conjunctivitis and not sarcoma. The subsequent history of the case has confirmed this opinion.

Dr. Shumway's report of the histological conditions is as follows:

The sections of the tissue measure 5 mm. by 2.5 mm. The greater portion of the growth is composed of a loose-meshed, fibrous connective tissue, which contains a moderate number of bloodvessels. It is covered by a thick layer of epithelial cells, which have a tendency to send inward processes of cells beneath the surface. Directly below the epithelial layer the mass is densely infiltrated with mononuclear round cells, and the bloodvessels contain a few polymorphonuclear cells. In places there are, in addition, larger, flat cells, which are arranged in nests and have the appearance of proliferated endothelial cells, such as are found in beginning alveolar sarcoma of the conjunctiva. Scattered between them is a small amount of light-yellow pigment. The majority of the cells, however, are small and represent ordinary lymphocytes, whose presence is due to irritation of the tissue. Some of them are broken down, their nuclei are fragmented, and the neighboring connective-tissue bundles have an œdematous appearance. The mass is evidently a new-growth, simulating a fibroma, with a decided inflammatory infiltration. The presence of the proliferated endothelial cells and the pigment is suggestive of commencing alveolar sarcoma. Similar cells, however, were described in a case of vernal conjunctivitis reported by de Schweinitz and myself, published in the *University Medical Bulletin*, and, in view of the clinical appearance and history, this portion of the growth should be considered of minor importance, and the diagnosis made of growth at the corneal limbus due to spring catarrh.

The chief points of interest in the case are:

1. The clinical and microscopic appearances of the growth so greatly resembling sarcoma.
2. The confinement of the ocular variety of spring conjunctivitis to one eye for nearly three years before it made its appearance in the other.
3. The fact that spring conjunctivitis was present in one eye for two years and eight months before the symptoms became sufficiently characteristic to permit a positive diagnosis to be made.
4. That the clinical history must always be given consideration in the establishment of a diagnosis from the study of a microscopic specimen.

INVESTIGATIONS OF THE NEWER METHODS FOR DIAGNOSING UNILATERAL KIDNEY LESIONS.

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AND

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Cystoscopy at last seems to have gained its well-earned place among the reliable and scientific diagnostic methods. Even strong opponents to its use, as James Israel, are now converted into ardent advocates of its diagnostic value, but the same is not yet true of ureteral catheterization. It seems as if the opposition is generally headed by those unfamiliar with its technique; to them ureteral catheterization appears to be a procedure of unsurpassable difficulty. They admit the desirability of obtaining urine from either kidney separately, but claim this end may be obtained with less danger and inconvenience to the patient and with the same accuracy for examining purposes by one of the many clever devices known as urinary segregators. Whoever has worked with these instruments will admit that they are more bulky and their introduction therefore more painful and dangerous to the patient than any of the ureteral